George H. Ryan, Governor
Jackie Garner, Director

Illinois Department of Public Aid

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Springfield, Illinois 62763-0001

Telephone: (217) 782-5565
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09/20/02

INFORMATIONAL NOTICE

TO: Enrolled Pharmacies and Outpatient Hospital Pharmacies

RE: Medicare Covered Drugs and Supplies – Revised Billing Instructions

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As you are aware, beginning with October 1, 2002 dates of service, for certain Medicare covered drugs and supplies identified by the Department, providers must bill Medicare first for participants in the Department's Medical Programs who are also enrolled in Medicare. The purpose of this notice is to provide you with revised billing instructions. These instructions replace the ones sent out in July 2002.

Please note, the attached billing instructions do not apply to SeniorCare claims. A separate notice will be mailed detailing the billing instructions for SeniorCare participants. This billing policy will be effective for SeniorCare participants beginning with October 16, 2002 dates of service.

In order to bill the Department of Public Aid for a Medicare enrolled participant, pharmacies must be enrolled with Medicare. For information on how to enroll in the Medicare Program, contact the National Supplier Clearinghouse at 1-866-238-9652. **Your pharmacy's Medicare provider number must be sent to the Department at the following address before the Department can process Medicare crossover claims.**

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

The participant's MediPlan card will indicate Medicare coverage. Refer to the Handbook for Providers of Medical Services, Chapter 100, General Policy and Procedures, Topic 108. The handbook is located on the Department's website at

http://www.state.il.us/dpa/handbooks.htm

An R36 error message "Part B service – bill Medicare" will be reported on the remittance advice for each service submitted on a claim for the Medicare covered drugs and supplies identified by the Department that had not been adjudicated by Medicare. A list of these drugs by HCPCS code can be found on the Department's web site listed above.

NOTE: Effective with dates of service on or after November 1, 2002, the Department will no longer accept the use of Department Generated Codes (99950XXXXXX) when billing for ostomy supplies. Providers must use the appropriate 11-digit product number, NDC or UPC.

Attached are detailed billing instructions, explaining how to bill the Department for Medicare covered drugs and supplies. When Medicare has made payment, the Department's payment will be the full co-insurance and deductible amounts for the drugs and supplies covered by Medicare.

The Department will waive co-payments for all drugs on the Department's list of Medicare covered drugs for which the Department is requiring that Medicare be initially billed. The co-payment will be waived regardless if the claim is found payable by Medicare and automatically crossed over to Medicaid or the claim is rejected by Medicare as not covered for that patient and the claim is subsequently billed to the Department.

Questions regarding this notice should be directed to the Bureau of Comprehensive Health Services at (217) 782-5565.

A. George Hovanec, Administrator
Division of Medical Programs

Attachment to Informational Notice regarding Medicare Covered Drugs and Supplies

MEDICARE CROSSOVER BILLING INSTRUCTIONS

Effective October 1, 2002

Coding and Submission of Claims to the Medicare Intermediary or Durable Medical Equipment Regional Carrier (DMERC)

Claims filed on behalf of participants eligible for both Medicare Part B and Medicaid, must first be submitted to the Medicare intermediary or DMERC on the HCFA 1500. Enter the Health Insurance Claim Number (HIC) in field 1a, the patient's nine-digit recipient identification number in field 9a and Illinois Department of Public Aid in field 9d. Field 27 must be marked "Yes" indicating that the provider accepts assignment.

In many instances, this entry will cause the claim to "cross-over." This means that the Medicare intermediary or DMERC will forward the claim to the Department automatically, without any further action by the provider. This is referred to as a crossover claim. When a claim crosses over, the Explanation of Medicare Benefits (EOMB) will contain the message; "This claim has been sent to the Illinois Department of Public Aid". Once the Department processes the claim, the claim will appear on a Remittance Advice.

Submission of Claims That Do Not Automatically Cross Over

For consideration of payment of Medicare's coinsurance and deductible on claims that do not automatically cross over, the provider must submit the claim directly to the Department. This should be done after:

- payment is made by the Medicare intermediary or DMERC, but the EOMB does not show that the claim has crossed over, or;
- more than 90 days has elapsed since receiving Medicare's payment and the claim has not appeared on a Remittance Advice from the Department.

In these situations, you must submit a copy of HCFA Form 1500, along with a copy of the Medicare EOMB to the Department. In order for the Department to process the claim, the following information **must** appear on the HCFA 1500:

- the provider name in Field 33 must be exactly as it appears on the Department's Provider Information Sheet, and
- the provider's Medicaid Provider Number must be entered in the lower right hand corner of Field 33, and
- if you have multiple payees listed with the Department, the one-digit provider payee code designated for the claim must be entered in Field 33 immediately following the Provider Name.

The disposition of the claim will be reported on a Remittance Advice.

Attachment to Informational Notice regarding Medicare Covered Drugs and Supplies
MEDICARE CROSSOVER BILLING INSTRUCTIONS
Effective October 1, 2002

Provider Action on Services Rejected by Medicare

The Department's liability for payment is based on Medicare's determination as to medical necessity and utilization limits. Before submitting a denied Medicare claim to the Department, the provider should review the reason for the denial to determine if submittal of the claim is appropriate. The provider should submit a claim to the Department for payment consideration when the reason for Medicare's denial of payment is one of the following:

- the patient was not eligible for Medicare benefits, or
- the service is not covered by Medicare.

In such instances, the Department should be billed only after final adjudication of the claims by the Medicare intermediary or DMERC. If the provider has requested a reconsideration of Medicare's denial, the Department should not be billed until after Medicare's reconsideration decision.

Claims that are denied by Medicare, for which the provider is seeking payment from the Department, must be submitted on a DPA Form 215, with a copy of the EOMB attached. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and all applicable correspondence should also be attached.

Some of the Medicare covered drugs are conditionally covered by Medicare based on a specific diagnosis or other restriction. Services for which a Medicare EOMB is received stating, the service is not covered for a particular beneficiary, are to be billed to the Department on the DPA 215 paper claim form with the copy of the Medicare EOMB attached. Subsequent refills for the beneficiary may also be billed on the DPA 215 with a copy of the original EOMB attached or the pharmacy may contact the Department's prior approval unit to request an override of the requirement to bill Medicare for refills. In the alternative, the pharmacy may contact the Department's prior approval unit to request an override of the Medicare edit so that the claim can be billed to the Department electronically through the point-of-sale system. Such an override may be requested either, after the claim has been rejected by Medicare as not covered or prior to billing Medicare if the pharmacy has sufficient information to establish that Medicare would not cover the particular service.